Continuity of Care Advisory Panel
Economic Workgroup Meeting Minutes
August 23, 2013

Prepared by Erin McMullen

Attendees

1. Dr. Stephen Goldberg (Chair)
2. Erin McMullen (DHMH Staff)
3. Suzanne Harrison
4. Elaine Carroll
5. Kait Roe
6. Dan Martin
7. Adrienne Ellis
8. Bob Wells
9. Steve Daviss
10. Scott Greene
11. Jane Plapinger
12. Derrick Richardson
13. Ryan Shannahan
14. Sarah Rhine
15. NaToya Mitchell

I. Approval of Minutes (8/16/13)
   a. Minutes from the 8/16/2013 meeting of the workgroup were approved with no changes.

II. Update on data request
   a. DHMH staff notified the workgroup that as of August 20, 2013 the data request was in production and will be sent to the workgroup in stages. The data workgroup may not be able to fill the entire request by September 4, 2013; however the data will still be sent for possible incorporation into the Advisory Panel's final report.
   b. It was suggested that the group streamline the data request to prioritize the data request. Inpatient data was identified as a priority by the group. DHMH staff will follow up with the data group to see if inpatient data can be sent first.
   c. Steve Daviss also sits on the data group and noted that data from ValueOptions should arrive first (hopefully next week). Data from the Health Services Cost Review Commission (HSCRC) will most likely not be available for another 2 to 3 weeks. The advisory panel's consultant is also working on pulling HSCRC data; however data authorization is still pending.
   d. Kait Roe asked the group whether or not the workgroup's report data could be changed. DHMH staff indicated that they would inquire with the department.

e. Kait Roe asked how the final report will be circulated for comments within the workgroup. It was also asked whether the group could use a google doc so everyone could make edits to the document.
    i. DHMH staff recommended against this because of the number of people in the workgroup.
    ii. Steve Daviss noted that you can set up google doc that no one could edit, but everyone could comment on it. Dr. Goldberg indicated that the workgroup would post the draft report in this format.
f. The workgroup asked when the Social Workgroup was going to meet. DHMH staff indicated that they would follow up on this topic.

III. Discussion and approval of draft outline

a. Dr. Goldberg presented the Draft Outline for the workgroup's final report to the Advisory Panel (see attached).
b. The report will be broken up into the following sections: (1) Executive Summary; (2) Economic Barriers for Consumers; (3) Economic Barriers for Providers; (4) System-wide Economic Barriers; and (5) Conclusions and Recommendations.
    i. Executive Summary: Dr. Goldberg stated that in this section of the report, the group will define its duties, summarize barriers, and acknowledge other workgroups of the Advisory Panel. It will be recognized that there are many economic barriers facing individuals with serious mental illness, but due to the group's time frame, only barriers related to continuity will receive focus.
        1. The executive summary will also distinguish between observations made by the group vs. recommendations.
        2. Scott Greene noted that we should include key findings and recommendations in the summary and the workgroup agreed.
        3. Kait Roe indicated that a quick description of the diversity of workgroup should be included in this section. DHMH staff noted that a more detailed membership of the workgroup could be included in the Appendix.
        4. Dr. Goldberg stated that this section should be no more than one page.
        5. Kait Roe noted that it this section should include a statement that the workgroup focused on "low hanging fruit" or areas that could be immediately addressed in the State's mental health system.
    ii. Economic Barriers for Consumers: Dr. Goldberg explained that this section of the report will include a discussion of barriers for consumers. Barriers can be different depending on an individual's insurance status, and the workgroup does not have a "one size fits all" approach for observations and recommendations. Barriers will be discussed for the following populations: privately insured, Medicaid population, individuals eligible for health insurance under the Health Benefits Exchange and the uninsured.
        1. Expanding access points to mental health services for all consumers will also be discussed. Adrienne Ellis asked the group if there is something

that can be said here regarding the costs of services, i.e. inpatient vs. outpatient services?

a. Dr. Goldberg agreed and noted that inpatient dollars are more concrete and can be tied to costs.
b. Suzanne Harrison stated that this should also be tied to ER utilization.
c. Kait Roe noted that this section should focus on the lack of providers, beds, crisis services, school based mental health programs, and geriatric psychiatrists. DHMH staff indicated that there is data available on health professional shortage areas and ER utilization.
    i. Dr. Goldberg stated that the only service that receives a high amount of funding is inpatient services. He noted that we need to free those dollars up for other things. By reallocating those dollars, we won't have to add to the State budget. Maryland is already in the top third of spenders nationwide for public mental health services. We should be doing more with what we have. Steve Daviss agreed with this sentiment.
    ii. Kait Roe was concerned that if money was redirected, that there wouldn't be money for inpatient services.
    iii. Steve Daviss asked what the costs were for individuals with forensic involvement. Dr. Goldberg said the report should focus on costs per inmate, per inpatient, per SRC, etc. Steve Daviss stated that indirect costs should also be noted. For instance, people may not be able to afford to take off work to go to an appointment.

2. Kait Roe requested the budget analyses for the Alcohol and Drug Abuse Administration and the Mental Hygiene Administration. DHMH staff indicated that they would provide these to the group.
3. Dr. Goldberg asked the group to define health literacy as it will be discussed in this section of the report. A description of the current system should be included. In terms of recommendations, health literacy is the most likely recommendation we can make.
    a. Dr. Goldberg asked the group what comes to mind for health literacy.
        i. Kait Roe spoke about the consumers' viewpoint. Medical jargon complicates the consumers' understanding of their health and the system. Information needs to be communicated at an appropriate reading level.

b. Dr. Goldberg asked what are the economic barriers that relate to health literacy.
    i. Elaine Carroll stated it was understanding choices, and services available. How can services help a person? A menu of services needs to be available to consumers, and linkages to those services need to be available. People need to know healthy ways of living.
    ii. Kait Roe mentioned that nutritionists aren't covered by insurance and this is a problem for those with behavioral health issues. Patients are scolded for making bad choices; however they aren't given access to better information and good choices. Childcare, daycare, and work are barriers to health literacy.
c. Dr. Goldberg stated that we aren't good at tying health literacy to care. People need to live a lifestyle that allows them to stay on the right medicine.
    i. Suzanne Harrison mentioned that discontinuity of care is a problem when people move from MCO to MCO, without realizing that it affects their choice of provider and potentially, their health outcomes.
d. Dr. Goldberg indicated that health literacy touches all aspects of your life.
    i. Elaine Carroll noted that this means that families should also receive appropriate information.
e. Kait Roe said culturally competency also needs to be considered.
f. Dr. Goldberg reminded the group that they needed to focus on economic barriers. What can move the needle?
    i. Suzanne Harrison stated that internal care management capacity is necessary to conduct care coordination.
    ii. Kait Roe asked whether we could incentivize group cooking and nutrition classes as it would make a huge difference to consumers.
g. Adrienne Ellis mentioned we should be focusing on areas where policies are already being developed. She overheard a provider discussing their Patient Centered Medical Home (PCMH) and how much money they were saving. However, the effects on the consumer were not discussed. She mentioned that PCMHs were low hanging fruit. The group should recommend that health literacy be included in the PCMH model and the State Innovation Model.

i. Steve reminded the group that PCMHs have to be certified, and certain things have to be included in their model. Consumer access to their health records is an issue. We need to address this here. Coordinating care between somatic and behavioral health helps improve quality of care, reduce costs, etc. Patients with co-occurring disorders cost more. Communication needs to be enabled. All behavioral health information can't flow through HIE. This needs to be addressed.

h. Dr. Goldberg made some recommendations on how we can improve health literacy:
    i. 3 mechanism for the State
        1. An ad campaign should be directed to the consumer. This could incorporate information that a consumer can't be denied a prescription if they are unable to make a copay.
        2. Communication should be made by the State with health entities. For instance, pharmacists should be informed that they can't deny a prescription because a patient can't afford a copay.
        3. Insurers, pharmacies, and whoever benefits from system should also be targeted by the State. Regulations should be promulgated that relate to literacy. For example, signs about copays should be posted at all pharmacies.
    ii. Dr. Goldberg also asked the group where these recommendations can be targeted.
        1. Adrienne asked the group whether they agree that the State needs to make health literacy a priority.

4. Continuity of Care
    a. Incentivizing/penalizing providers who do not share information at "hand-off"
    b. Incentivizing/penalizing providers
        i. Kait Roe mentioned that she read that penalties don't work.
        ii. Steve Daviss agreed and noted that comparing physicians to their peers does work.
        iii. Dr. Goldberg asked whether we should be publicizing continuity of care of providers.

1. Adrienne Ellis stated that the Maryland Health Care Commission does this for insurers.

iv. Steve Daviss asked if we can find a way to indicate what percentage of handoffs are communicated? Dr. Goldberg noted that not communicating has economic costs. Continuity of care attestation should be built in to the system. Steve Daviss doesn't think that would work. The best way to do this is through Electronic Health Records (EHR) penalties. If information is available in the Health Information Exchange (HIE), then you don't have to worry about the handoff as much.

c. Dr. Goldberg indicated that this is a barrier for providers, but we should use it as a conduit to the third section of the report.

iii. Dr. Goldberg indicated that the third section of the report - Economic Barriers for Providers – would be discussed in the google group. This section includes:

1. HIE exclusion;
2. HER utilization; and
3. Telemedicine.

iv. Dr. Goldberg presented the fourth section of the report - System-wide Economic Barriers . This includes a discussion of insurance generally.

1. Insurance
    a. Dr. Goldberg mentioned that the adequacy of existing provider rolls should be discussed. There should be a penalty for failing to maintain an accurate provider directory. Consumers should receive a provider directory prior to joining. There needs to be protection for the consumer.
    b. Appeal processes should be in place.
    c. Transparency of processes was also included in the outline. Dr. Goldberg asked the group whether this should be expanded in State regulations.
        i. Adrienne Ellis informed the group that the Maryland Insurance Administration (MIA) can enforce this for private health insurance now. DHMH can enforce with MCOs. However, enforcement isn't occurring. Steve Daviss said that this is the case because it is a complaint driven process. MIA had roughly 50 complaints on inadequate provider directories. Dr. Goldberg said this needs to be tied back to health literacy. The system needs to be educated; hospitals and clinics should make complaints, too. Steve Daviss thinks this could be more self-regulated. There should be a phone number to MIA on all provider directories. We should require carriers to

put information next to a provider's name and include information on how often they accept a new patient. The directory should be sorted by claims connections. Social media should be integrated into directories.

ii. Adrienne Ellis reminded the group that market conduct reviews are driven by complaints at MIA. A complaint driven process isn't enough. MIA needs to do a better job policing by taking a proactive approach.

d. Dr. Goldberg indicated that we should shine a light on the complaint process, recommend more responsiveness in the provider directories, and advertise MIA.

2. Elaine Carroll stated transitional age youth need to be discussed here.
3. Other topics in this area will be discussed in the google group, including Mental Health Parity, medication, telemedicine, HIE exclusion, and EHR utilization.
4. Suzanne Harrison informed the group that hospitals are viewed predominantly as providers of inpatient services, whereas in most hospitals, the balance has shifted to outpatient, especially in psychiatry where many provide a full continuum of care from most to least intensive. Hospitals also are often the consumer's chosen community based provider of care because of the ability to one-stop shop for both psychiatric and somatic services. They are also often the easiest to access in terms of available transportation. The State is increasingly reluctant to pay the HSCRC rates that hospitals must use to offset their requirement to serve the uninsured, and has indicated their belief that consumers can receive "routine care" from non-hospital community based providers. The State believes that hospital services should only be used by the most clinically complex patients. However, where consumers receive care along the full continuum of services offered by a hospital, forcing them to go to non-hospital community based providers fragments their care and has the potential for poorer outcomes due to the discontinuity. Before forcing this divide between hospital based and non-hospital based providers, the State needs to evaluate the total cost of care for consumers. . When continuity of care suffers because of enforced fragmentation to ensure short term financial gains, the overall cost of care may, in fact, prove higher.

a. Steve Daviss noted that if a hospital chooses to charge HSCRC rates, then they charge higher rates. This creates huge price discrepancies. One solution is that hospitals could choose to deregulate community outpatient space. This will be less of a problem under the ACA.

b. Suzanne Harrison disagreed that hospitals should electively deregulate space and again emphasized the need to look at total cost of care across the continuum of services utilized, not simply at component pieces.
    i. Dr. Goldberg posed the question whether it is possible to argue, that routine care should be available in a hospital at a lower rate? Ms. Harrison feels this is unrealistic given hospitals' mandate to serve the uninsured.
    ii. Kait Roe asked how we include patient choice in this process. How do we balance economic barriers with patient choice?

v. Inpatient Bed Space will also be addressed in this section.
    1. Steve Daviss wanted to know whether this included all beds. Dr. Goldberg responded that it did.
    2. Dr. Goldberg noted that the outline included forensic bottlenecks. He explained that everyone in our system is presumed competent until otherwise addressed. If competency is brought up, then nothing proceeds in the criminal justice system until this issue is addressed.
        a. Kait wanted to know what the size of this group is. However, the workgroup is still waiting on its data request.
        b. Steve Daviss noted that the vast majority of private hospitals don't take forensic patients. He estimated that maybe 15 beds in the State have forensic patients.
        c. Sarah Rhine asked the group whether this should be handled in the courts, jails, and state hospitals? Dr. Goldberg responded that once the State hospital is bottlenecked, the State system is affected, because people linger in inpatient settings and outpatient programs. Sarah Rhine questioned whether we should distinguish between those who are made competent quickly? There are those who need long-term intensive treatment. Dr. Goldberg agrees with her, people who have long term needs do not belong in jail setting.
        d. Dan Martin noted that jail-based competency restoration doesn't sound like something the group could recommend due to time constraints. Dr. Goldberg noted that maybe by next week we can? Kait Roe noted she would like to know opinions of other groups. For instance, what are the pros and cons of jail-based competency programs?
        e. The workgroup noted that other workgroups need to talk about this as well.

3. Dr. Goldberg explained the current process for how we determine whether an individual is competent to stand trial.
    a. The Office of Forensic Services conducts an outpatient evaluation to determine whether an individual is (1) competent, or (2) possibly not competent.
    b. If they are possibly not competent, competency to stand trial is determined at the State hospital. It is at this point where the State tries to restore competency.
    c. An opinion is then rendered as to whether an individual can be restored. They may return to jail at this point.
    d. People cycle in and out of the State hospital and jail throughout this process.
    e. Dr. Goldberg noted that this has an impact on State hospital system, an impact on available in-patient bed space throughout the system, and an impact on emergency room utilization. These items are included on the draft outline for the report.
4. By instituting a jail-based competency restoration program we could open up beds in the community for civil commitments, etc.
    a. Sarah Rhine mentioned that medical panels in correctional facilities are costly. Dr. Goldberg asked Sarah to provide the negative aspects of conducting competency restoration in a jail-based setting.
    b. Dr. Goldberg informed the group that Arizona's Title 36 allows for things to be done in the correctional setting. Services are physically provided in correctional unit. However, a separate team provides competency restoration, a higher level of programming, and forensic assessments. In this program you don't have to wait for outpatient assessments, inpatient beds, etc.
5. Outpatient civil commitment. The report will discuss the historical context, pros and cons, and examples from other states (New York and Arizona).

IV. Discussion Topics
    a. Outpatient civil commitment
        i. Dr. Goldberg referenced an email the group received from the Maryland Disability Law Center (MDLC). MDLC opposes outpatient civil commitment. He also noted that this may be a grey area for individuals.
        ii. This topic will be discussed further in the google group.

V. Adjourn